Offer #401-HHS-003

Medical Assistance, Medical Contracts, IowaCare and HIPP

This offer includes the following appropriations: Medical Assistance, Medical Contracts, and IowaCare

Contact: Jennifer Vermeer jvermee@dhs.state.ia.us (515) 256-4621

Program Description:

This offer includes the Medicaid program and the administrative costs necessary to administer the program and deliver the health care benefits. Medicaid covers a comprehensive range of health care services for Iowans who meet the program's eligibility criteria. The services are delivered through private hospitals, pharmacies, physicians, nursing facilities, and other health care providers located throughout the state.

The key characteristics of the program are the following:

- Medicaid is a federal program operated by the state. It is an entitlement program under Title XIX of the Social Security Act. That means that the state must cover services to all those found eligible and may not arbitrarily reduce the amount, duration, or scope of services.
- The program is financed with state and federal matching funds. Federal funds will finance approximately 60% percent of the Medicaid program in Iowa in SFY 2013.
- Medicaid eligibility is based on a combination of income and other criteria that must be met. Generally, Medicaid covers low income individuals who are aged (over age 65), blind, or disabled, pregnant women, children (under 21 years of age), or members of a family with dependent children.
- Medicaid covers a comprehensive package of acute care services (hospital, pharmacy, physician, etc.) as well as long-term care services (nursing facility, institutional care, and home and community based services) for individuals who are disabled.

All states operate Medicaid programs. While each state's program is different in how expansive their eligibility or service coverage is, or the degree to which they have managed care organizations in their programs, all of the programs are very similar and face similar issues. For example, when the economy worsens, and unemployment increases, more people become eligible for and access the Medicaid program to cover their health needs. This has been true in Iowa, although enrollment growth has slowed recently as economic conditions have improved. In SFY 2011, enrollment increased by 5.4 percent; down from 9.4% in SFY 2010. In all states, Medicaid programs are a significant part of the health care delivery system. The Iowa Medicaid program is the second largest health care payer in Iowa, following Wellmark.

The program is expected to serve over 698,000 Iowans or nearly 23 percent of the Iowa population in FY 2013.

Total Medicaid expenditures (state, county and federal) in FY 2013 will be nearly $4.0 billion. This $4.0 billion will fund payments for medical services to over 38,000 health care providers statewide.

Payments are made to physicians, hospitals, labs, pharmacies, home health providers, rural health providers, federally qualified health centers (FQHCs), nursing facilities, chiropractors, physical therapists, home care providers, and many other types of providers. The impact of Medicaid on any individual provider varies by the type of service the provider delivers, and the population they serve. For example, Medicaid makes up between 10-20 percent of most hospitals' revenues, but is, on average, about 50 percent of nursing facilities' revenue. In the area of services for the disabled (such as Intermediate Care Facilities for the Mentally Retarded – ICF/MR), Medicaid is often the primary or only revenue source.

The program's match rate brings in nearly $2.2 billion in Federal dollars into the State. In order to draw the Federal funds, the state must fund the required State match.

The State matching funds consist of:

- $1,015 million from the State General Fund.
- $106 million from the Health Care Trust Fund (revenue from the tobacco tax).
- $60 million from other funds including the IowaCare Fund, Pharmaceutical Settlement Fund, and the Health Care Transformation Account.
- $45 million from the State Resource Centers and State Mental Health Institutes.
- $263 million from county/local funds. In Iowa, counties pay for the non-Federal Medicaid match for certain services for adults with chronic mental illness or intellectual disabilities. Other appropriations within the DHS budget are made to the counties that they can use to offset their Medicaid State match costs.
- $219 million from other revenues such as recoveries and drug rebates.
- $7.9 million from the CHIPRA Performance Bonus Payment. The Performance Bonus provides added Federal funding for qualifying States that have increased Medicaid enrollment of children above a baseline level. To qualify during a Federal fiscal year, a State must be implementing during the year at least five of eight program features that simplify the applications and renewal process. The children that count toward the bonus payment are children enrolled in Medicaid who meet eligibility criteria in effect on July 1, 2008. These qualifying children include children enrolled in CHIP-funded Medicaid expansion programs. It is projected that Iowa will qualify for the bonus in SFY 2013.
- $7 million in transfers from the University of Iowa Hospitals & Clinics.
- $5.3 million in carry-forward dollars from the prior fiscal year.
- $2 million from the Medicaid Fraud Account.
- Nursing facility and hospital assessment fees. These fees are charged against providers' total revenues and generate funds that are used to increase Medicaid payment rates to the facilities and also generate a net gain in revenue to the State. These provider assessment fees provide the following in revenue to the Medicaid program:
    - $26.5 million from the Nursing Facility Quality Assurance Trust Fund, implemented April 1, 2010.
    - $33.9 million from the Hospital Health Care Access Trust fund, implemented July 1, 2010.

Medicaid program expenditures grow each year due to enrollment growth and increasing health care costs, just as costs do in the private health care system. Medicaid expenditures grow even more quickly during recessions or economic downturns when more individuals become eligible for and access the program. The expenditure growth is largely due to growth in enrollment – the average increase in the cost per person has been 0 percent for the past five years. Expenditures are also driven by the cost of long-term care. Nearly half of the Medicaid budget is dedicated to institutional and community based services for elderly and disabled populations who need help with activities of daily living.

Affordable Care Act

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, has a number of provisions affecting Medicaid and CHIP. This Federal health care reform legislation is complex. Key changes affecting the state Medicaid programs include:

- Development of 'Exchanges' for individuals to purchase insurance.
- Tax subsidies to assist those between 133percent - 400 percent of the Federal Poverty Level (FPL) to purchase insurance.
- Mandate to expand Medicaid coverage to 133 percent of the FPL. Eligibility will be based solely on income and no longer limited to those who are aged, blind, disabled, children, pregnant women, or members of a family with children.
- New requirements for streamlining Medicaid eligibility procedures.
- Maintenance of effort (MOE) requirement. States are unable to make Medicaid eligibility standards, methodologies or procedures more restrictive until the establishment of the insurance exchanges for adults (effective 1/1/2014) and until 10/1/2019 for children.

The Department recognizes the need to plan and strategize around key components of this Federal legislation, particularly in the area of Medicaid expansion. The expansion will increase Medicaid enrollment in Iowa by approximately 25 percent (110,000 to 130,000 Iowans) by 2020. This includes the transition of IowaCare enrollees to the full benefit Medicaid plan.

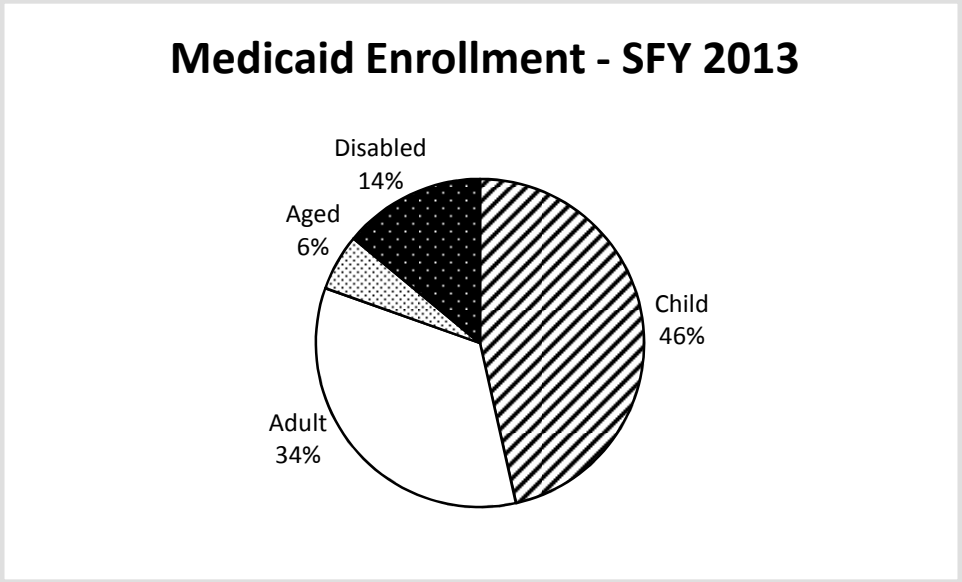
As a result, the Department is in the process of procuring a new eligibility IT system that will modernize eligibility determination to include real-time and on-line eligibility processing that may be integrated with the Health Benefits Exchange. The 2011 RIIF bill included $3 million over three fiscal years in state funds for the system replacement. The actual cost of the system will not be known until the Request for Proposals (RFP) process is complete.

Who:

The Department of Human Services estimates that the Medicaid program will have more than 698,000 individual Iowans enrolled over the course of SFY 2013. As noted above, Medicaid will provide health care coverage for nearly 23 percent of Iowa's population at some point during the year.

The Medicaid population consists of four general categories and is projected to serve the following in SFY 2013:

- 324,581 children
- 236,998 low-income parents and adults
- 97,809 persons with disabilities
- 38,972 elderly persons



In order to be eligible for Medicaid, individuals must not only be low-income, they must also fall into one of the federally mandated categories: they must be children, frail elderly, disabled persons, pregnant women, or very low-income parents. This leaves many single persons and couples without dependent children ineligible for Medicaid, even if they have no income. Beginning January 1, 2014, under the Affordable Care Act, this will change when Medicaid will cover all Iowans below 133 percent FPL.

There are several eligibility groups within Medicaid (included in the figures above) that receive a different level of benefits than the 'full-benefit' Medicaid program. These groups typically have higher income and the benefits are targeted to specific populations. These eligibility groups may have premium requirements, more limited benefits, or they may not be entitlements.

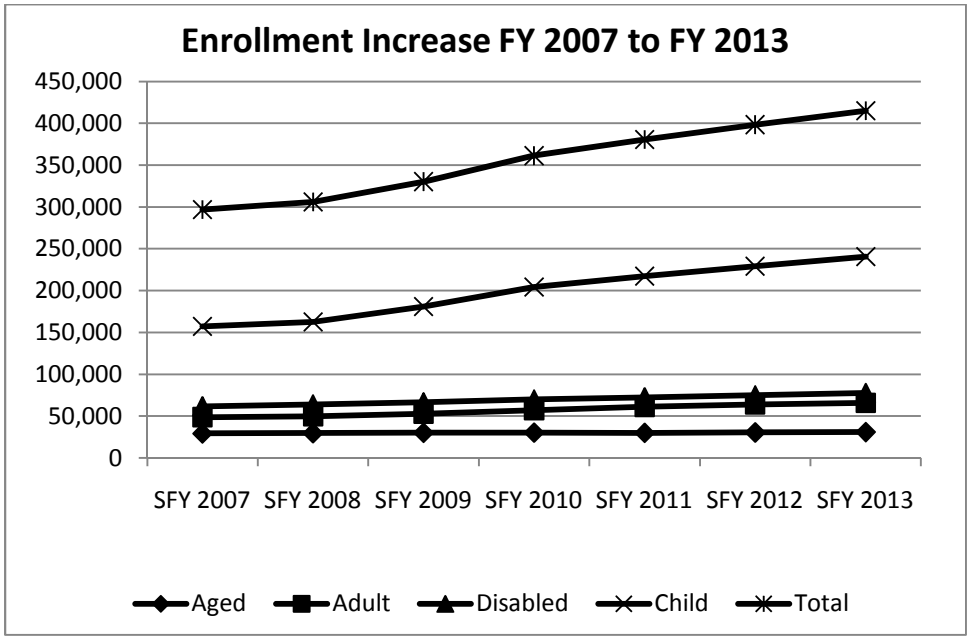
- **QMB** - For persons who are Qualified Medicare Beneficiaries (QMB), Medicaid covers only the cost of Medicare premiums, deductibles, and co-payments.
- **IowaCare** – The program is an 1115 demonstration waiver and covers persons (with incomes below 200 percent of the Federal Poverty Level) who do not fit one of the standard Medicaid categories. The covered services are limited to inpatient and outpatient hospital services, physician services, and limited dental and transportation services. Members have access to a limited number of providers. Historically, only the University of Iowa Hospitals and Clinics in Iowa City and Broadlawns Medical Center in Des Moines were IowaCare providers. Senate File 2356 expanded the provider network to include up to 14 Federally Qualified Health Centers and adopted a medical home model.

The FQHC's will be phased-in over 2 years, beginning with Siouxland Community Health Center (Sioux City) and Peoples Community Health Clinic (Waterloo) on October 1, 2010. In SFY 2013, the IowaCare program is expected to cover 91,171 adults. (See Appendix for more information about IowaCare).

- **Family Planning Waiver** – This program is also an 1115 waiver and covers family planning services for individuals who do not qualify for the regular Medicaid program. Beginning in SFY 2012, the Legislature provided authority for the department to amend the current medical assistance waiver for the Iowa Family Planning Network. The changes will increase the income limit to 300 percent of the Federal Poverty Level, require coverage for women and men up to the age of 55, and cover women and men whose health insurance does not cover benefits provided under the waiver. This is expected to significantly increase the number of individuals accessing the Family Planning Waiver. A projected 62,820 individuals will receive these services in SFY 2013.

Overall enrollment in Medicaid has been increasing each year since 1996. Enrollment growth increased significantly in SFY 2010, but slowed in SFY 2011. Prior to SFY 2011, enrollment increases for children, parents and the disabled were above historical averages, while elderly population growth remained stable. In SFY 2011, growth in all categories was much closer to the historical average.

The largest growth since 1996 is for children. Since the beginning of SFY 2011, Medicaid enrollment increased by 13,341 individuals -- children accounted for 64 percent of this growth. The following table shows actual and projected enrollment growth for each category since SFY 2007.



The large growth in children is due both to the economic downturn, where families have lost access to health coverage due to employers dropping health coverage, unaffordable premiums, or losing the job altogether, as well as due to State policy efforts to expand coverage for children.

What:

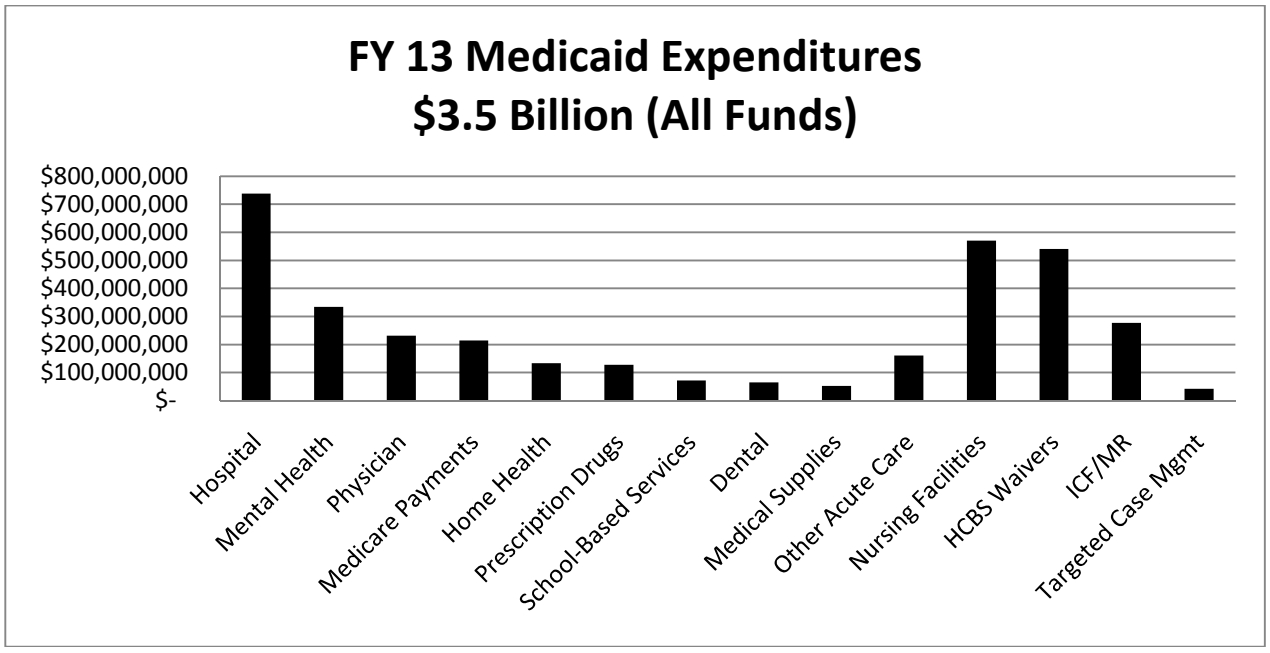
Iowa Medicaid pays for medically necessary health care services, including acute care services typically covered in any health insurance program. These include hospitalization, physician and advanced registered nurse practitioner (ARNP) services, dental care, emergency transportation by ambulance, laboratory, x-ray, and other services. Coverage also includes comprehensive mental health services delivered through a contracted managed care entity (known as the Iowa Plan), and includes rehabilitative mental health services (known as Behavioral Health Intervention services). The BHIS program was restructured through a year-long stakeholder workgroup and transitioned to the Iowa Plan in SFY 2012.

The Medicaid program has a panel of more than 38,000 dedicated providers including hospitals, physicians, dentists, pharmacies, medical equipment providers, and many other health care providers of all types.

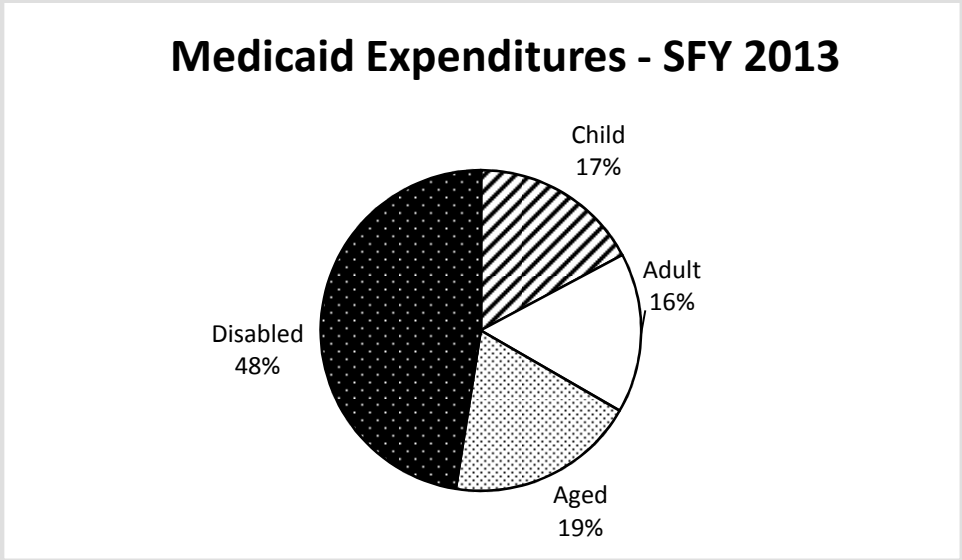
In addition to traditional acute care services, Medicaid provides coverage for long-term care services, such as nursing home care, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), and home and community based care that allows individuals to stay in their own homes or other small congregate settings. Long-term care services provided at home, such as home health, assistance with personal care, homemaking, and respite care allow individuals to avoid or delay institutional care.

Home and community based care is delivered through seven 1915(c) waivers that are targeted to specific populations including: Elderly, persons with Intellectual Disabilities, persons with Physical Disabilities, Children with Serious Emotional Disturbance, HIV/AIDS, Ill and Handicapped and persons with Brain Injury. The waiver programs are typically less expensive than institutional care and have a great deal of demand – all waivers, except the Elderly waiver, have waiting lists for new enrollees. Some waiting lists are over a year long to access the programs. This speaks to the desire of members to live in their own homes and communities as much as possible. In Iowa, and nationally, Medicaid programs finance the majority of services in the disability system, and for approximately half of nursing facility care. Counties pay the non-federal share for services to adults with intellectual disabilities and for certain services for adults with mental illness.

The cost of medical care for different Medicaid populations varies significantly. The average cost for each child in Medicaid is much lower than the average cost for each disabled or elderly person, since elderly and disabled individuals utilize more long-term care services. As shown in the charts above, although children make up 46 percent of the Medicaid population, they account for only 17 percent of total expenditures. This difference is true nationally as well. As noted above, there are a number of smaller programs within Medicaid that cover only a subset of the full-benefit package.



The table above reflects Medicaid provider payments across major service categories. In addition, this offer includes other transfers and administrative costs that total $4.0 billion dollars. Acute care expenditures account for approximately $2.1 billion in expenditures, while long term care (the last 4 categories on the right side) account for $1.4 billion.



How:
Medicaid pays for Medicaid covered services that are provided to eligible members, by enrolled Medicaid providers. The reimbursement methods vary across provider types. Medicaid is the 'payor of last resort', and as such has reimbursement rates that are often lower than private insurance or Medicare. For providers that serve almost exclusively Medicaid members (i.e., long term care providers), the rates are based on the cost of service.

Medicaid, as a payor of health care services, has all of the same responsibilities as any third party payor. The administration for the program is known as the Iowa Medicaid Enterprise (IME). The core business functions of operating the program include the following:

- Processing and paying claims submitted by providers for services they delivered to members. Medicaid pays nearly 23 million claims per year. The average time from receipt of the claim to payment is less than seven days.
- Medical management functions are performed by medical professionals and include prior authorization of certain services to ensure the service is medically necessary, ensuring members meet the 'level of care' requirements to receive long term care services, disease management programs, quality assurance, review of utilization to ensure the program is cost effective in the services provided.
- Provider network management, including contracting with providers, provider services call center and training, and reimbursement analysis and rate setting.
- Member services call center.
- Cost avoidance and recovery when other insurance is present, from estate recovery, insurance settlements/lien recovery and provider overpayment. Medicaid collects over $218 million in revenue to offset state and Federal costs (this amount includes drug rebates).
- Pharmacy management and claims payment. The IME operates a Preferred Drug List that saves the state over $30 million annually.

Iowa has undertaken innovative approaches to managing these programs and improving the quality of services. Iowa seeks to not simply be a payor of health services, but to manage high quality and cost-effective health care. The Iowa Medicaid Enterprise operates the Medicaid and IowaCare programs by integrating "best in breed" private contractors to efficiently process medical claims, work with providers and members, and aggressively pursue cost recovery. Provider surveys show satisfaction has increased since implementation of the IME. Average wait time for a provider to talk to a call center representative is less than 20 seconds.

Medicaid will also pay the premiums for private insurance if cost effective (called the Health Insurance Premium Payment Program (HIPP)). In SFY 2011, the HIPP program provided a net savings to the Medical program of nearly $13 million (state and federal). Historically, the administrative costs for the HIPP program have been in a separate appropriation, but in SFY 2012, these costs moved within the Medical Assistance appropriation.

Other strategies include disease management programs, smoking cessation coverage, an electronic health record, preventive medical exams, Medicaid Value Management (MVM) which allows the IME to identify areas we need to target management strategies, multi-state drug purchasing pool, Preferred Drug List, and premiums.

In the past year, Medicaid has significantly expanded program integrity efforts to pursue overpayments, identify coding errors, and identify fraud and abuse. These increased efforts are projected to result in savings and cost avoidance to the Medicaid program of more than $22.5 million (state and federal).

Medicaid has a number of large technology projects that are currently in progress that will enable significant changes in how Medicaid operates and the health care system as a whole.

- **5010 and ICD-10 Transaction Standards** - The Health Insurance Portability and Accountability Act (HIPAA) requires changes in the way payors and providers process electronic transactions (from Version 4010/4010A1 to Version 5010 and NCPDP D.0) by 1/1/2012. The law also requires the migration of all diagnosis codes used in health care billings (moving from standard International Classification of Disease (ICD)-9 to ICD-10. All services provided on or after 10/1/2013 must use the new code sets. The code sets will provide greater specificity regarding the medical encounter. Health plans that cannot process the new code sets as of 10/1/2013 face significant penalties. These changes require very significant system and process changes for all payors and providers.
- **Medicaid Management Information Systems (MMIS) replacement** - The MMIS is a 30 year old system that supports all Medicaid claims processing and information systems. The IME is in the process of procuring a new MMIS system. Funding was provided in the 2011 Rebuild Iowa Infrastructure Fund legislation to support the replacement. This project will take place over the next four years. A Request for Proposals has been issued and the vendor is expected to be in place by January 1, 2012.
- **Eligibility System Replacement** – In order to comply with the Affordable Care Act, DHS has determined that the eligibility system that processes Medicaid and other programs eligibility must be replaced. The current system is a 30-year old mainframe system and cannot handle the new eligibility and verification rules, connection to a state or federal health benefits exchange, and real time eligibility and enrollment in the program. A Request for Proposals is planned to be issued in Fall 2011 with the project completed by October 2013. Funding was provided in the 2011 Rebuild Iowa Infrastructure Fund legislation to support the replacement.
- **Medicaid EHR Incentive Program** - Iowa Medicaid continues to administer the Medicaid Electronic Health Information (EHR) Incentive program. Iowa has currently paid over $13 million to 140 providers and anticipates this to grow to $256 million to 1200 providers over the next 10 years. Payments are 100% federal funds. IME provides technical assistance and outreach to encourage providers to adopt and meaningfully use electronic health records. This program was authorized under the federal American Recovery and Reinvestment Act.
- **Iowa Health information Network -** The Iowa Health Information Network, operated by the Department of Public Health will allow providers to securely share medical records and clinical test results with other providers. Medicaid will support the creation of the IHIN through funding (leveraging CMS HITECH funding opportunities), and active participation in IHIN council and workgroups. In addition to medical record review processes, IME will be utilizing the Health Information Network to capture clinical information for meaningful use verification, quality metrics for new payment models, and input to analytics for financial modeling and disease management support.

The Medicaid program also has responsibility for contracting with other agencies, such as the Department of Public Health for various health education and care coordination programs for children.

Service Delivery
The magnitude and duration of the current economic recession have had a significant impact upon the demand for services under this offer. The number of cases for which Income Maintenance Workers are responsible has dramatically increased over the past two years.

- For every 861 income maintenance cases, there is one specialized income maintenance worker (IM2) assigned. The level of cases per worker has steadily increased as the number of workers has decreased going from 481cases per worker in 2009 to 693 in 2011.

The Department and the Division continue to seek out new efficiencies and consolidate functions wherever the cost and benefits to Iowans can be demonstrated. One example is the centralized service area, established in 2010, that brought together existing units (e.g. the Income Maintenance Customer Service Center) and established new units to deal with the reduced staffing levels and create efficiencies. The new units include; Child Care Registration and Payments, Centralized Child and Dependent Abuse Intake and the Nursing Facility Eligibility Unit. Full details of the work and challenges faced by field staff can be found in Offer #401-HHS-016.

NOTE: Federal Maintenance of Effort in Medicaid prohibits the state from reducing Medicaid eligibility or implementing new waiting lists through SFY 2014.

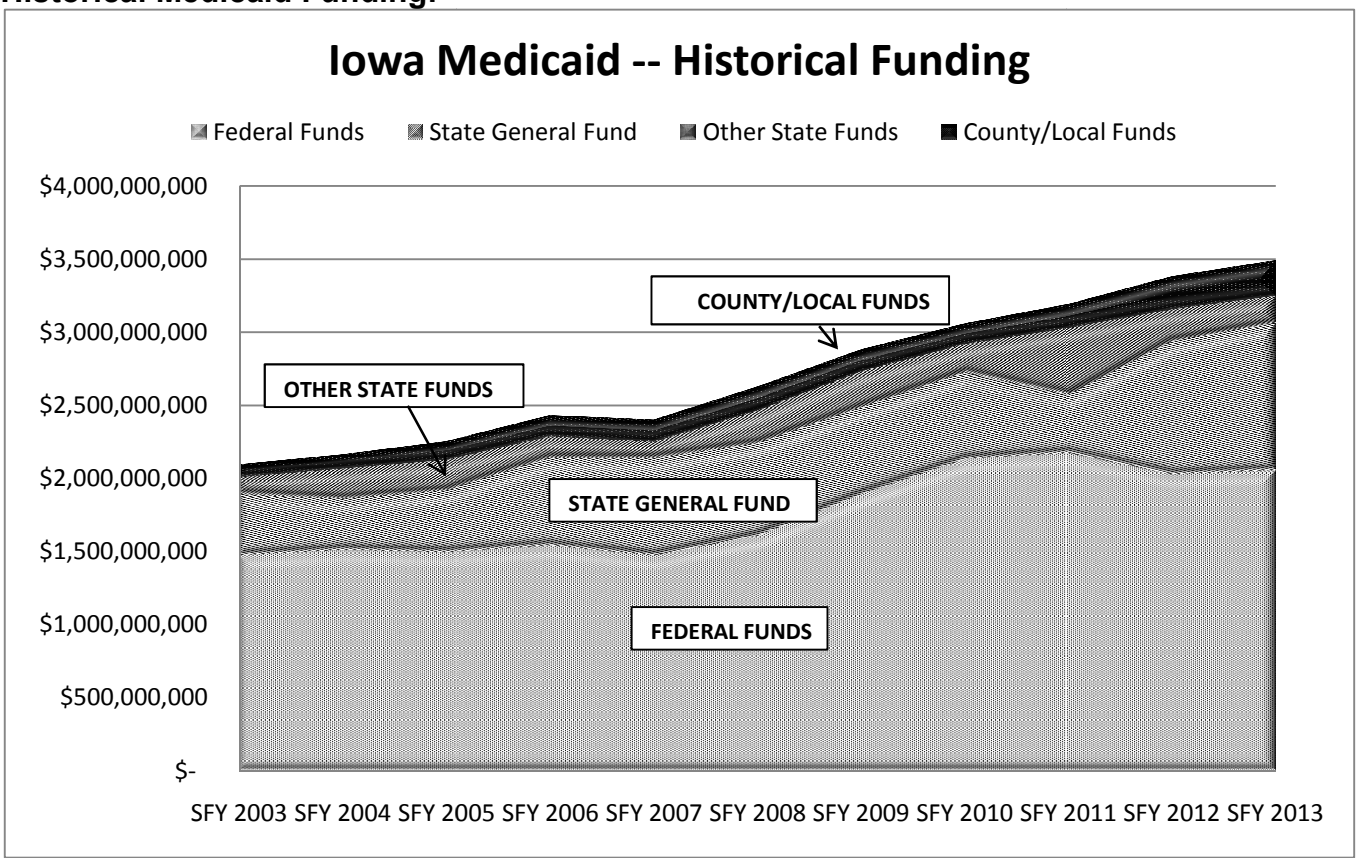
Service Support
The Medicaid program is administered by the Iowa Medicaid Enterprise (IME). The IME is made up of 24 State FTEs (excluding CHIP staff) managing nine performance based contracts with private vendors. The staff perform the policy function and management of the vendors. The vendors carry out the majority of the business functions of operating the program. State and contract staff are co-located in a single facility to ensure integration of the vendor operations with the program management. The funding for the state staff is included in the “General Administration” appropriation, and all Medicaid contracts are funded from the “Medical Contracts” appropriation.

The General Administration budget includes State staff who are directly responsible for providing program oversight and support, performing the following functions:

- Overall Departmental oversight
- Program Support – policy development, administrative rules, provider and employee manual, Medicaid State Plan, Iowa Code
- Member and Provider Relations – appeals, exceptions to policy
- Communication – State/Federal relations, legislative requests
- Legal Support via the Iowa Attorney General’s Office
- Information Technology – maintenance of existing systems and development of new and/or enhanced systems to improve efficiencies and customer service
- Financial Accountability – budget, accounting, federal/state reporting, cost allocation, audit coordination and resolution
- Contract Management/Purchase of Services
- Postage – distribution of provider payments
- Responsible for compliance, administration, and integrity of the Medicaid program

The Field and General Administration FTEs are included within separate offers, but this offer does include 12 FTEs to administer the Health Insurance Premium Payment program.

Historical Medicaid Funding:



The preceding chart shows the financing for Medicaid over the past 10 years. Beginning in SFY 2009, federal funds increased due to ARRA. In SFY 2011, the "other funds" were increased and General Funds decreased. In SFY 2012, the General Fund share increases significantly due to the expiration of ARRA and the replacement of one-time funding sources. The funding distribution in the SFY 2013 budget request will be similar to the distribution in SFY 2012.

Current Results:
The offer maintains the current eligibility levels and covered services for recipients of Medicaid and IowaCare. The offer addresses projected growth in enrollment in the program due to economic conditions, as well as changes in utilization patterns and costs.

In total, this offer results in an increase in General Fund support from the status quo level of $91.7 million for SFY 2013. The offer assumes that the provider rates in place in SFY 2012 will continue in SFY 2013. One exception to this is the Affordable Care Act requirement that certain physician services be reimbursed at 100% of the Medicare rate beginning January 1, 2013.

The detail for the increase is as follows:

- $90,892,864 for increases in the Medical Assistance program. Further detail behind this increase is provided below:
  - $30,647,597 to replace other revenues that will not be available in SFY 2013. This includes an assumed loss of Federal dollars due to a decline in Iowa's regular FMAP rate ($32.2M), a replacement of a transfer from the Iowa Veterans Home ($3.8M), and a reduction to the CHIPRA Performance Bonus ($1.6M). This is partially offset by a $5M increase to the SFY 2013 general fund appropriation and a $2M increase to the Medicaid Fraud Account appropriation.
  - $24,879,439 to replace carry-forward dollars that were available in SFY 2012, but will not be available in SFY 2013. This includes both a General Fund carry-forward ($20.7M) and a Hospital Health Care Access Trust Fund carry-forward ($4.2M).
  - $14,145,733 for increases in fee-for-service categories such as physicians, clinics, and prescription drugs. $9.9M is due to enrollment growth of 4.16% over SFY 2012. $4.2M is due to inflationary increases; primarily in those categories where reimbursement is based on actual cost (rural health clinics and federally qualified health centers). Prescription drugs also saw an inflationary increase due to the annualization of the SFY 2012 dispensing fee increase.
    - Of the $4.2M inflationary increase, $1.2M is due to the Affordable Care Act requirement that certain physician services be reimbursed at 100% of the Medicare rate beginning January 1, 2013. Although this increase is to be funded with 100% Federal funds, there will be a state cost because the 5% provider rate reduction implemented in SFY 2010 must be restored before the 100% Federal match rate begins.
  - $9,054,650 for increases in hospital services. $7.6M is due to enrollment growth of 4.16% over SFY 2012. $1.5M is due to inflationary increases resulting from the annualization of hospital rebasing implemented in SFY 2012.
  - $8,537,056 for the home and community-based waivers. $6.9M is due to recipient growth resulting from the annualization of the waiting list buy-down that occurred in SFY 2012, the legislatively mandated waiting list buy-down in SFY 2013, and enrollment increases in the Elderly Waiver. $1.6M is due to utilization/inflation increases across all waivers.
  - $5,390,662 for increases in Medicare-related payments. $2.5 million is due to a 5% increase in Buy-In recipients and 1% increased in Part D Clawback recipients. $2.9M is due to inflationary increases resulting from a 4% increase in Medicare Parts A & B premiums and a 1.2% increase in Part D Clawback payments.
  - $4,204,025 for an IowaCare transfer. A $4.2M IowaCare shortfall is expected in SFY 2013, and it is assumed the Medical Assistance appropriation will cover this difference.
  - $4,131,768 for growth in mental health-related services which includes the Iowa Plan, Habilitation, PMIC and Psychiatric services. $3.7M is due to recipient increases; largely driven by Iowa Plan enrollment. $0.4M is due to utilization/inflation increases in these categories.
  - $2,094,472 for increases in PMIC ancillary services. CMS is requiring that ancillary services (physicians, prescriptions drugs, etc.) be included within the PMIC rate. This will require PMICs to separately contract for these medical services and bill Medicaid for the cost, rather than having Medicaid pay for the services directly. PMICs will not likely be able to negotiate rates equal to Medicaid rates and would

not collect rebates on prescription drug payments. Therefore, this will increase costs to the Medicaid program.
- $1,416,510 for managed care increases. The increase is primarily due to the expansion of Iowa's Program of All-Inclusive Care for the Elderly (PACE). A new provider will be joining the PACE program mid-year in SFY 2012, and this is expected to increase recipient counts by over 50%. The annualized impact of this increase will be felt in SFY 2013.
- ($2,282,483) for a reduction in nursing facility payments. A 1.5% decline in bed days is anticipated. In addition, rates for most facilities will be unchanged due to SFY 2013 being a non-rebasing year.
- ($8,342,521) for hospital upper payment limit (UPL) timing differences. Annual hospital UPL payments total $56.5M. Due to timing differences, the FY 11 payment will be $35.1M and the FY 12 payment will be $77.9M. The FY 13 payment will be the correct annual amount of $56.5M. The variance between FY 12 and FY 13 results in a state dollar reduction of $8.3M
- ($2,984,045) for increases and decreases in all other Medical Assistance programs/payments. This includes items such as targeted case management, ICF/MR, medical transportation, health insurance premium payments, administrative payments, recoveries, and transfers to other appropriations.

- In addition, this offer includes an increase of $820,031 for Medical Contracts. The increase is primarily due to pre-determined increases in the IME contracts, increased rent to provide space for vendor staff, and additional investments in health information technology and uniform cost reporting. This is partially offset by reductions in IME reprocurement costs.

Improved Results:
The Medical Services offer will improve the following results:
- Implement an asset verification system.

Asset Verification System – Budget Neutral
The Asset Verification System (AVS) is designed to verify the assets of aged, blind, and disabled applicants for and recipients of Medicaid. Federal law (Title VII. Section 7001 (d) of P.L. 110-252 (Supplemental Appropriations Act of 2008) requires that state Medicaid agencies implement an AVS by September 30, 2012. The system must be consistent with the approach taken by the Social Security Administration's (SSA) Supplemental Income asset verification pilot project. States have a few options for implementing AVS. States can choose to contract with SSA's contractor, another outside contractor, or design their own system. Iowa will conduct a Request for Proposals process to select a vendor. The benefit of this program is that it will provide for increased accuracy in Medicaid eligibility determination.

<u>What is required?</u>
- States are required to add "asset verification programs" to their Medicaid plans.
- Individuals whose Medicaid eligibility is being determined or redetermined (and others whose finances are relevant to eligibility) must authorize the state Medicaid agency to obtain records from any financial institution in connection with the eligibility determination in order to verify individual's assets.

- Individuals who refuse or revoke their authorization may be determined ineligible for medical assistance.

Cost Neutrality Analysis

The Department averages 40,476 SSI-Related Medicaid applications per year, of which on average, 2,412 are denied for excess resources/income. This results in a denial rate of 5.96%. In order for the asset verification system to be cost neutral, the Department would need to deny an additional 83 applications in SFY 2013. We believe that estimate is achievable, resulting in a cost neutral program, at a minimum and projected savings in the long run. The proposal is budget neutral but will require a transfer from the Medical Assistance Program appropriation where the savings will accrue to the Medical Contracts appropriation, where the contract cost will be expended.

General Fund Cost SFY 2013: $393,689
General Fund Savings SFY 2013 (83 denials): $394,416

Legal Requirements:

Title XIX of the Social Security Act authorizes and stipulates the requirements for the Medicaid program. These requirements are further detailed in the Code of Federal Regulations beginning at 42 CFR 440. The Federal regulations require any state that operates a Medicaid program to include, at a minimum, specific services for individuals who fit into defined categories. Federal regulations at 42 CFR 440.210 and 42 CFR 440.220 require that inpatient and outpatient hospital, physician, lab and x-ray, nursing facility, physician services, nurse midwife and nurse practitioner services must be provided. In addition, this requirement indicates attention to care for pregnant women. Further, the Iowa Code also defines the services and eligibility categories the Iowa Medicaid Program is required to cover. This offer maintains our statutorily required services and populations.

Results Achieved:

Result:	SFY11 Actual Level	SFY12 Projected Level	SFY13 Offer Level
Percentage of State long-term care resources devoted to home and community based care.	23.02% including the Nursing Facility (NF) QA Assessment Fee	24.8% Including the Nursing Facility (NF) QA Assessment Fee	26.54% including the Nursing Facility QA Assessment Fee
Medicaid strives to assure that members are receiving services in their communities whenever possible. The funds spent for all long-term care is compared to those spent for community services.	25.74% with NF QA Assessment Fee	26.53% without NF QA Assessment Fee	28.88% without NF QA Assessment Fee

Proportion of 15-month-old children with well-child visits. 0 visits 1 visits 2 visits 3 visits 4 visits 5 visits 6 visits	 17% 83% 73% (est.) 63% (est.) 53% (est.) 43% (est.) 32% *	 15% 85% 75% 65% 55% 45% 40%	 14% 86% 80% 70% 60% 50% 42%
Percentage of EPSDT eligibles who received a preventive dental service from a dentist. Total EPSDT eligibles who received dental treatment services.	34.4% 16.3%	35.4% 16.3%	35.4% 16.3%
Proportion of persons with asthma where appropriate medications are used.	82%	84%	85%
Proportion of women receiving prenatal care from the first trimester.	68% *	70%	72%
State savings from pharmacy cost saving strategies, including PDL.	$13.3 M (SMAC) Prior listed dollars were Total not state only. $52.6 M projected (PDL) *Total rebates up so savings increase; increase in FMAP rate also increases state share of costs plus savings.* Note: Do not yet have complete rebate impact due to Health Care Reform	$17.6 M (SMAC) $54.5M (PDL) Note: Do not yet have complete rebate impact due to Health Care Reform	$ 17.95 M (SMAC) $ 59.8 M (PDL) Note: Do not yet have complete rebate impact due to Health Care Reform

Savings from utilization and care management strategies. The Medical Services Unit reviews requests for prior authorization to determine medical necessity and recommend alternatives. Data on utilization are used to develop a savings over what would have been spent without such oversight.	$10,000,000	$10,700,000**	$11,500.00
Savings from program integrity. This dedicated unit uses nationally accepted standards and data mining tools to search the claims database and find instances where payments may have been made incorrectly. The amount of overpayment recoveries is set by the contract with the entity performing this function.	$23,070,919	$22,500,000 ***	$25,000,000
Increase over the prior year in revenue collections from third parties. The collections (including cost avoidance measures) for SFY 2008 were 39.33% higher than the goal. Overall, the enhancement of the goal from year to year as specified in this contract would appear sound. The contracted performance measure is 15%.	-3%	15%	15%

Increase in member satisfaction with administration of Medicaid program based on survey results. With the new contractor on 7-1-2010 IME began an annual survey. First year results for calendar 2010 (SFY 11) set the baseline at 92 percent very satisfied or satisfied (73 percent and 19 percent respectively. IME member Services will continue to try to move this higher but also improve the 'very satisfied' number.	92%	92% Combined ranking of very satisfied and satisfied.	93% Combined ranking of very satisfied and satisfied.
Percent of members aware of Member Services A survey is performed annually by the Public Policy Center at the U of Iowa. A more recent survey (2010) is in process and results are not yet available. The increase is an optimistic but achievable demonstration of the effort to make members aware of this helpline.	42%	48%	52%
Percent increase in provider satisfaction with the Provider Services Unit over prior year, based on survey results	2% Survey results expected in October	2%	2%

% of receipt days where clean claims are accurately paid or denied on time as per federal regulations. The federal requirement is for 90percent of clean claims to be paid in 30 days and 99 percent in 90 days. The IME currently shows that the average payment delay for a clean claim is less than 10 days.	100%	100%	100%

* Healthcare Effectiveness Data and Information Set (HEDIS) measures are used to describe these results and are gathered by the University of Iowa Public Policy Center (PPC) annually. These are compared with national standards and benchmarks. HEDIS data reports are currently only available for SFY 2010 (in DRAFT form only at the time of this writing). Actual HEDIS data cannot be utilized until claims data has been finalized and that is generally determined by the PPC at 24 months following the fiscal year. The SFY 2012 and subsequent year goals are taken from the PPC report and recommendations for future year goals.

** Table shows projected amount for SFY 2011. Actual amount for SFY 2011 will not be available until October 2011 based on new performance measures will be implemented based on new contract and scope of work for IME Medical Services.

*** Beginning in SFY 2011, savings are to be determined in dollars rather than in percent.